Report on the Statewide Provider Database
Virginia Department of Health

September 15, 2000

Authorization

Item 305 #2h of the Appropriation Act, 2000, requires that "the Department shall report on the efficacy of the statewide provider database that was to be established as part of the Robert Wood Johnson Foundation "Practice Sights" grant. The Departments report shall (i) identify the reasons for not having completed the development of the system during the "Practice Sights" grant period; (ii) identify what additional actions and resources are needed to complete the development of the provider database; and (iii) establish a timeframe for completing and implementing the database. The department shall complete its review and report its findings and recommendations to the Chairmen of the Senate Finance and House Appropriations Committees and the Joint Commission on Health Care, by September 15, 2000."

Background

Designations of primary care health professional shortage areas (HPSAs) at both the federal and state levels are based on the ratio of primary care physician practice-site-specific full-time equivalents (FTEs) to the population within a bounded area (e.g., county, city, census tract). Receiving a designation as a shortage area qualifies the area for a number of benefits, incentives, and other forms of assistance from over 30 federal and state programs (see Appendix A for a list of programs using HPSA designations as part of their eligibility criteria). These forms of assistance include: monetary assistance through improved reimbursements; eligibility to recruit physicians from National Health Service Corp, National and State Loan Repayment and Scholarship recipients, and J-1 Visa Waiver recipients; and the ability to provide incentives to the recruited physicians to enhance their retention rates. Conversely, the inability to attain HPSA designations results in lost primary care financial and employment opportunities for the Commonwealth.

Virginia historically has not been able to identify efficiently and effectively its primary health care shortage areas because it has lacked a centralized database with the needed information. In order to determine if a particular area were eligible to be designated as a shortage area, Virginia had to manually pull together disparate data sets from a variety of sources - a tedious and time consuming task. Consequently, a number of areas in Virginia were missing opportunities to receive forms of assistance for which they were eligible.

The Robert Wood Johnson (RWJ) Practice Sights Initiative was a national program conceived by the RWJ Foundation to increase access to primary care services in underserved areas. The Virginia Department of Health (VDH) Center for Primary Care and Rural Health (the Center), in collaboration with the Joint Commission on Health Care (JCHC) and the Virginia Health Care Foundation, applied for and received grant funding from the RWJ Practice Sights Initiative. The development of a statewide primary care provider database was one of the five key objectives proposed in the grant. The purpose of the statewide primary care provider database was to assist in the accurate identification of the need for primary care providers throughout the Commonwealth. Additionally, the database would assist in the data collection and documentation required for the designation of primary health care shortage areas. The Center, whose activities include recruitment and retention of physicians and designation of health professional shortage areas, was given the responsibility for the development of the statewide primary care provider database. The grant period ran from 1996 through 1999.

The Year 2000 budget amendment directing VDH to report on the statewide provider database was a recommendation of the JCHC following a 1999 study of health workforce issues in the Commonwealth (House Document #89, 2000). The study report indicated that the statewide primary care provider database was incomplete and wasn't being used by the Center. The report additionally noted that the Center staff were uncertain as to the usefulness of the existing database and unclear as to whether or not the database would

indeed provide a more efficient means of assessing primary care needs and designating shortage areas than the current method of manually verifying and updating data.

Barriers to the Completion of the Statewide Provider Database

During the grant period, the Center developed a comprehensive database of primary care physicians. However, this did not satisfy the requirements of the type of database that was proposed in the grant. The predominant barrier to the completion of a relational (the ability to link data from multiple data sources into one database using a common data element) statewide primary care provider database was an inadequate assessment of the feasibility and costs of the project at the grant proposal stage. Conceptually, a relational database appeared to be relatively simple to the grant writers. It was not until after the grant funding period had begun that the actual logistics of creating these linkages were explored. The true magnitude and costs attached to the task did not fully emerge until well after the start of the grant. In the final analysis, the grant writers underestimated the complexity and costs associated with the development and maintenance of a relational statewide database of primary care providers.

As proposed in the grant, the statewide provider database was to contain comprehensive data on primary care physicians (pediatricians, family practitioners, internists, general practitioners, and OB/GYNs), nurse practitioners, and physician assistants. The data elements required in the data set for the purposes of planning and by federal regulations for the designation of shortage areas included:

- a determination of full-time equivalents (number of hours worked by each provider by practice site);
- area of specialization of the provider;
- status of participation in Medicaid by the provider;
- age of provider;
- provider's hospital admitting privileges;
- provider's board certification status; and
- employment of mid-level practitioners by the provider.

In order to capture all of the required elements, data from the following agencies and organizations would need to be obtained and merged into one database:

- Department of Medical Assistance Services (DMAS)
- Virginia Department of Health Professions (DHP)
- American Medical Association (AMA)
- U.S. Census Bureau
- Virginia Employment Commission (VEC)
- American Board of Medical Specialties

The Center took on the painstaking process of manually comparing the various databases, determining discrepancies, and making corrections to the data files. The AMA master

file was used to augment the DHP licensure files and to standardize spelling and married and maiden names. Specialty information was confirmed with the database of the American Board of Medical Specialties, and practice sites were identified through a database that included the business white pages and yellow pages for Virginia. The resulting data set contained a comprehensive listing of 7,965 primary care physicians (1,293 pediatricians, 1,771 family practitioners, 3,340 internists, 464 general practitioners, and 1,097 OB/GYNs) in Virginia. The addresses in the partially-developed provider database were then tested by the VDH Office of Epidemiology, which used the provider database as their source for quarterly mailings to Virginia physicians. Over 10% of the mailings were returned due to incorrect addresses. The Center proceeded to track down the correct addresses and amend the data accordingly. After a year of quarterly mailings, the returned mail percentage had not changed.

The VDH Office of Epidemiology continues to use for its quarterly mailings the primary care physician data set initially developed for the RWJ Practice Sights Grant. Additionally, the Center, in spite of its limited manpower, has managed to keep up with the manual updating/verification process, allowing for the timely submission of redesignation and new designation applications. The Center has also developed a database of all designated primary care, dental and mental health care professional shortage areas in Virginia.

Another complex issue that was underestimated in the grant was the use of the computer system. As proposed in the grant, a Primary Care Management Information System Manager (Pri-CAM) was to be hired and consultant services were to be secured in the first year of the grant period. A relational database would be developed by the 2nd year of the grant period. Costs were projected to be approximately $70,000 per year for each of the two years. The grant writers were, however, unaware of the complexities of using the VDH Oracle® system. As a result, the Pri-CAM brought on for the project did not possess the level of technical skills necessary for such an ambitious project. The Oracle® system database software proved to be extremely complicated, requiring the Pri-CAM to seek out extensive consultation services. Consulting fees were in excess of $30,000 annually (almost one half of the projected annual budget). In fact, costs exceeded budget for the project by over $30,000 annually for each year of the grant (total costs were approximately $100,000 per year) and funds were expended primarily on system maintenance rather than on database development.

Shortly after completion of the grant period, the Center experienced the loss of several staff members due to career advancement opportunities. As a result, one new staff was hired to maintain and update the Oracle® system statewide primary care provider database in addition to several other job responsibilities. The new staff member found the Oracle® database to be extremely cumbersome and a decision was made at that point to convert the provider database from Oracle® format to Microsoft Access format. This conversion has been completed by the Center and has eliminated the high ongoing costs of consultation services related to the use of the Oracle system.

Additional Actions and Resources Needed to Complete the Statewide Primary Care Provider Database

Between the commencement of the Practice Sights Grant 1996 and its completion in 1999 several significant legislative events occurred. In the 1998 session Senate Bill 660 was passed which authorized the Virginia Department of Health Professions, Board of Medicine (DHP) to collect detailed educational and practice data on physicians of medicine or osteopathy. This was amended in 1999 (Senate Bill 975) to include all podiatrists. In response to these amendments to the *Code of Virginia* (§54.1-2910.1), regulations have been promulgated (18VAC85-20-280) and enforcement provisions (18VAC85-20-3000) were put in place in January 2000. The General Assembly authorized the establishment of the DHP Physician Profiling database through appropriation in the 1998-2000 biennium budget, $300,000 the first year and $250,000 the second year to be generated by dedicated special revenues from increases in physician licensing fees. The increases in physician licensing fees that began in April 2000 are being used to support the DHP database. DHP issued a Request for Proposals for an interactive web-based physician profile, with practice-site-specific information and a contract has been awarded. This database is expected to be online by July of 2001.

The proposed physician survey instrument developed by DHP contains much of the information that the Center recommended collecting to support the HPSA certification process. The following data elements, critical to the HPSA designation process, are included in the database:

- multiple practice addresses;
- the percentage of practice time devoted to each practice site;
- insurance information; and participation in the Virginia Medicaid Program; and
- acceptance of new Medicaid patients.

The most important feature of the proposed web-based physician profiling system is that it must be updated by the physician in written form or by electronic filing within 30 days of any change in information. Failure to comply with this updating requirement is grounds for disciplinary action by the Board of Medicine. Although this requirement provides the structure needed for the database to remain current, at present, because of cost constraints, there are no mechanisms in place to verify the accuracy of information to be contained in the DHP Physician Profiling database.

The DHP database will facilitate securing data for the HPSA designation process and will facilitate health planning in the area of the primary care workforce. However, the Center must still verify manually all of the necessary data and certify their accuracy for the federal program. This responsibility resides with the Center through its cooperative agreement with the federal Bureau of Primary Health Care (BPHC). The BPHC Division of Shortage Designation requires that (1) the Center certify the data and (2) the Center collect additional information, namely physician FTE's per worksite and the percentage of the Medicaid patients seen by a practice. The "discounting" of certain physician

groups, namely active National Health Service Corp physicians, non-permanent resident physicians, and physicians on visa waivers, will remain to be determined and taken into account by the Center.

The importance of the DHP Physician Profiling database for the HPSA certification process must be stressed. This database will be of substantial benefit to the study of the health access process by:

- reducing the time required to research physician providers and determine whether an area can potentially be designated as a HPSA;
- allowing health workforce planning analysis on a scale that was not previously allowable, e.g., studies of mobility patterns of physicians, tracking Virginia Medical School and residency program graduates, analyzing the aging of the physician workforce in medically underserved areas of the Commonwealth, calculating retention rates for physicians;
- studying the ability of physician groups to provide access for a culturally diverse population;
- assisting in determining the availability of providers for an indigent or Medicaid population; and
- providing the public with a readily accessible database of local physicians and the information needed to evaluate a physician's competence.

While this database will facilitate primary care health workforce analysis, it does not:

- establish a relational database as envisioned in the RWJ Practice Sights Grant;
- include nurse practitioners and physician assistance as specified by the RWJ Practice Sights Grant;
- include dentists or dental practice sites. With dental practitioner shortages, designating dental HPSAs have become a major concern to the Center and the Commonwealth;
- include jurisdiction boundaries such as census tracts that are often key to obtaining shortage designations; and,
- provide for a systematic validation process for the database.

The objective originally proposed in the RWJ Practice Sights Grant for implementation of a statewide primary care provider database has been significantly furthered by the development of the DHP Physician Profiling database. Any primary care database needs to be seen as a subset of this larger DHP physician database effort. To complete the originally planned primary care physician database (excluding Nurse Practitioners and Physician Assistants) would require:

- Developing a Memorandum of Agreement with the Department of Health Professions to supply the Center with the primary care physician subset of data from the Physician Profiling database;

- Expanding the Department of Health Professions database on primary care physician with information required for the HPSA designation process;
- Systematically developing the appropriate relational databases to fulfill the needs of all primary care health planners and policymakers within the state. To accomplish this final requirement, VDH would take the lead in convening a taskforce of all stakeholders;
- Supporting the on-going recruitment and retention efforts of the Center in primary care by tracking all scholarship and loan repayment physicians and all primary care practitioners who have completed medical school or residency within the Commonwealth;
- Developing a relational database format that is easy to query and available to a broad spectrum of stakeholders including community health planners;
- Developing a web site, which will incorporate demographic data, health statistics and health outcomes, and geographical mapping of primary care physician offices;
- Developing a systematic validation process for the primary care provider database; and
- Developing an annual reporting format on the state of primary care workforce issues within the Commonwealth.

Timeframe for Completing the Primary Care Provider Database

Discussions have been initiated by VDH with DHP and other parties concerning their interest in facilitating the Center's primary care provider database. A primary care provider database taskforce has been formed and will begin meeting early in 2001.

A proposed annual budget for the database development and maintenance can be found in Appendix B. This budget is prepared in response to the enabling legislation and should not be construed as a budget request.

The proposed primary care physician-practice-site-specific relational database would be completed in 2002. The data would be presented in a publicly available format on a web site dedicated to primary care workforce issues in the Commonwealth.

Appendix A:

Programs and Grants that Use Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA) Designations as a Requirement, Criteria or other Screen.

Programs and Grants that Use Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA) Designations as a Requirement, Criteria or other Screen

Program Title and Description	How HPSA Or MUA Designations Is Used In Determining Need For Program	Enabling Legislation	Contacts & Est. Funding FY99
1. PROGRAMS THAT INCREASE THE NUMBER OF HEALTH CARE PROVIDERS IN UNDERSERVED AREAS			
National Health Service Corps The NHSC increases access to primary health care services in HPSAs. The NHSC was initiated through the Emergency Health Personnel Act, Amendments of 1987. The HPSAs designation was originally set up to specify areas eligible for NHSC participation. A NHSC participant must be located in a HPSA designated as needing the same provider type. If located in a population designation, the practice must provide care to the designated population at a specified level. Data generated from the designation process is also used to determine how many NHSC members an area is eligible for and to screen out low priority areas. Specific programs include:			
National Health Service Corps Scholarship Program (93.288) *provides scholarships for tuition, fees and other expenses to students in health professions. Participating students must contact to serve in an HPSA for one year for each year of support with a minimum obligation of 2 years. At this time, students of allopathic and osteopathic medicine, Family NP, nurse Midwifery and primary care PAs are eligible.*	NHSC must be located in a HPSA designation for the same provider type. If located in a population designation, the practice must provide care to the designated population at a specified level. Data generated from the designation process is also used to determine how many NHSC members an area is eligible for and to screen out low priority areas. NHSC designates high priority sites from HPSAs and recipients are matched with sites based on	National Health Service Corps Act, 1987 & 1990 Amendments; PHS Act, Title III, Sections 331 thru 338A & 338C thru 338H.	Chief, Loan Repayment Programs Branch, Division of Scholarships and Loan Repayments, BPHC, (301) 594-4400 (or 1-800-638-0824 $28,521,250
National Health Service Corps Loan Repayment Program (93.162) provides for the repayment of educational loans for individuals who have completed graduate or under- graduate training in a health profession. Participants contract to practice in an approved loan repayment program service site in a HPSA for one year for each year of support with a minimum obligation of 2 years. The program provides a tax assistance payment of 39% for each year of service.	NHSC designates selected HPSAs as "loan repayment program service sites". Priority is given to health professions trained in a discipline needed by NHSC and who show commitment to continued service in underserved areas. Participants must serve for a minimum of two years.	National Health Service Corps Act, 1987 & 1990 Amendments; PHS Act, Title III, Sections 338B	Chief, Loan Repayment Programs Branch, Division of Scholarships and Loan Repayments, BPHC, (301) 594-4400 $ 37,554,450
Grants for State Loan Repayment (93.165) provides a 50% matching grant to states to operate a program for the repayment of student loans for health professionals similar to the federal program. States must follow the NHSC Criteria but can develop further criteria for locating recipients in high priority areas.	States can develop criteria for prioritizing HPSAs as State Loan Repayment Program (SLRP) practice sites within the requirements of the federal program. In Washington, priority is based on: service to underserved and remote populations; location in a high need area; high vacancy rate, etc	National Health Service Corps Act, 1990 Amendments; PHS Act, Title III, Section 3381	Chief, Loan Repayment Programs Branch, Div Scholarships and Loan Repayments, BPHC, (301) 594-4400 $ 6,000,000

Program Title and Description	How HPSA Or MUA Designations Is Used In Determining Need For Program	Enabling Legislation	Contacts & Est. Funding FY99
Community Scholarship Program (Demonstration Grants to States for Community Scholarships (93.931) grants funds to increase delivery of primary care in urban and rural HPSAs. Funds are provided to community for scholarships. Recipients must contract to provide a year of health for each year they receive a scholarship with a minimum of two years. Scholarship can be provided for MD, NP, CNM, or PA training in internal or family medicine.	Service must be done in HPSA designated areas with a shortage in the recipients field. This program is not funded at this time. It may be reestablished during HNSC reauthorization.	Disadvantaged Minority Health Improvement Act of 1990; PHS Act, Title III, Section 338L	Chief, Loan Repayment Programs Branch, Division of Scholarships and Loan Repayment, PHC; (301) 594-4400 $ 0
Medicare Incentive Payments Program Under this program, HCFA gives a 10 percent bonus payment for Medicare-reimbursable physician services provided within geographic HPSAs. It also provides higher "Customary Charges" for New Physicians in HPSAs. The law directs HCFA to exempt new physicians opening practices in non-metropolitan, geographic HPSAs from new Medicare limitations on "customary charges".	Service must be provided within a designated HPSA.	Public Law 100-203, Section 4043 and Section 4047.	

Nursing Education Loan Repayment Program (NELRP) (93.908)A Grants are meant to assist in the recruitment and retention of professional nurses in Eligible Health Facilities (EHFs). All participants must enter into a contractual agreement to provide full-time clinical care in an approved EHF located in a HPSA with a shortage of nurses. In exchange, for a 2-year service commitment, the NELRP will pay 60 percent of the participant's total qualifying educational loan balances	Participants must contact to serve in an Eligible Health Facility. EHFs are identified by and must be located in a HPSA. They can include: Public Hospitals; Migrant Health Centers; Community Health Centers; Rural Health Clinics.	Section 846 of the Public Health Service (PHS)	Nursing Education Loan Repayment Program, BPHC 301/549-4400 $2,279,000
Mental Health Clinical and AIDS Service-Related Training Grants (93.244) encourages mental health specialists to work in areas where severe shortages exist; increase the number of minority personnel in the mental health professions, and the number of mental health personnel trained to deal with special populations including rural populations.	No criteria listed for selecting proposals lists HPSAs, MUAs or other shortage areas. However, the first objective listed is to encourage specialist to work in areas where severe shortages exist.	PHS Act, Title III, Section 303; Public Law 78-410	Anne Mathews-Younes, Human Resource Planning and Development Branch, Center for Mental Health Services, SAMHSA, DHHS; 301/443-5850 $ 401,524

Program Title and Description	How HPSA Or MUA Designations Is Used In Determining Need For Program	Enabling Legislation	Contacts & Est. Funding FY99
***Indian Health Professions Scholarship Program (93.972**) provides scholarships to American Indians and Alaska Natives at health professions schools in order to obtain health professionals to serve Indians. Scholarships support students in courses of study in health professions needed by the Indian Health Service (HIS). Needed health professions are updated on a regular basis. Recipients are required to perform one year of service for each year of financial support.	Obligated service can include private practice in a **Manpower Shortage Area** that provides health care to a substantial number of Indians.	Indian Health Care Improvement Act Amendments of 1988, Section 104	Ms. Patricia Lee-McCoy, HIS Scholarship Program; Indian Health Service, 301/443-0243 $ 7,000,000
J-1 Waiver Program Foreign medical graduate can enter the US for residency training with a J-1 Visa if they return to their own country at least 2 years after their training is completed. A J-1 Wavier allows these graduates to remain and practice medicine if they do so in an HPSA .	Physicians receiving a J-1 waiver must sign a contract to practice for 3 years in a HPSA. The USDOA also has a J-1 Waiver program which they administer separately from the states. They require that service be done in a rural HPSAs.		Immigration and Naturalization Service or USDOA.

2. PROGRAMS THAT PROVIDE FINANCIAL SUPPORT TO UNDERSERVED AREAS			
Programs/Grants for Health Centers - PHS Act, Title 3, Section 330: Grants given under this section are for health centers which are defined as "an entity that serves a population that is medically underserved, or a special medically underserved populations comprised of migratory and seasonal agricultural workers, the homeless and residents of public housing by providing"…primary health services and other supportive services as appropriate…" "Medically underserved populations" are defined as the population of an area designated as an area or population with a shortage of personal health services. Medically underserved populations are designated by the DHHS. A state may also recommend designation based on unusual local conditions that limit access to or availability of primary health services.			
Community Health Center Grants (93.224) provides grants to public organizations to establish and operate community health centers (CHCs) and health networks in medically underserved areas (MUAs). CHCs provide primary and preventive health care including dental care, preventive care, prenatal and ancillary services such as laboratory tests, pharmacy services, etc. Centers can also provide services to facilitate access such as transportation and translation.	A CHC must be located in an area designated as a MUA or MUP. Priority is given to providing services in the most underserved areas and maintaining existing centers serving high priority populations.	Health Centers Consolidation Act of 1996; PHS Act, Title 3, Section 330(c)(d) & (e)	Richard C. Bohrer, Director, Community and Migrant Health , BPHC, 301-594-4300, $ 786,250,000
Migrant Health Program (93.246) provides funding to public or non-profit organizations to establish and operate Migrant Health Centers (MHCs). MHCs provide access to medical care services to migrant and seasonal farmworkers and their families. In addition to the services provided by CHCs, MHCs can provide environmental health care. Requirement for some services may be waived with a showing of good cause.	MHCs provide primary health services to a special medically underserved population – migratory agricultural workers. MHCs must provide service to this population within a designated catchment area.	The Migrant Health Act; PHS Act, Title 3, Section 330(g)	Adolfo Mata, Director, Migrant Health Program, 301/594-4303 $ 79,165,000

Homeless Populations (93.151) *provides grants to provide for primary health services and substance abuse services to homeless individuals and families including homeless children.* ***Residents of Public Housing (93.927)*** *provides grants to improve minority access to primary care services and reduce infant mortality for residents of public housing.* *Section 330(f) provides for grants to address infant mortality. However, no grant programs were found that were authorized under this section.*	*While these programs are authorized under Section 330, which is intended to provide service to MUA/MUPs, subsections 330(h) and (I) refer to special MUPs. The grant programs do not require or reference MUA/MUPs. They do consider justification of need based upon demographic and/or health status indicators. Migrant workers are also considered a special MUP but designation is required. Apparently, a distinction was made based on the fact that MHC grant must service a designated catchment area while homeless and public housing grants do not have to.*	*Health Centers Consolidation Act of 1996 (Public Law 104-299); PHS Act, Title 3, Section 330(h) & (I).*	*Dr. Regan Crump, Director, Division of Programs for Special Populations, BPHC; 301/594-4420* *$ 72,596,000 & $ 10,265,000 respectively*
Technical and Non-Financial Assistance to Health Centers and NHSC Delivery Sites (93.129) provides assistance to health centers and NHSC sites. Projects can involve state agencies in assuring primary care to MUAs, developing shared service and purchasing arrangements, training and technical assistance for R&R, clinical development, and assessment of community health needs. Funds are not available to health centers that serve the homeless or residents of public housing.	Priority is given to projects that support primary care for MUPs and that assist NHSC sites (which must be located in HPSAs) and other R&R for primary care providers which are located in areas of highest need (e.g., large migrant/seasonal farmworker population). Data collected are used for an annual report to Congress on the distribution of funds to meet the health care needs of MUPs and on the appropriateness of the delivery system.	*Health Centers Consolidation Act of 1996; PHS Act, Title 3, Section 330(k)*	Director, Office of State and External Affairs BPHC, 301/594-4488. $ 13,500,000
Primary Care Services/ Offices (93.130) provides grants to states that establish and coordinate local, state and federal resources contributing to primary care service delivery to meet the needs to MUPs through health centers and other providers and R&R for MUPs. Grants can also be used for states to enter into agreements with DHHS to analyze the need for health services, review and comment upon health center's budgets and plans and to provide TA to centers.	Applicants are evaluated on unmet need for primary care services, disparities in health outcomes and it's strategies and activities to response to these problems.	Health Centers Consolidation Act of 1996; PHS Act, Section 330(k), 330(m) and 333(d).	Office of State and External Affairs, BPHC, HRSA; 301/594-4488 $ 11,000,000
Rural Network Development Program (93.912) funds are provide to expand access to, coordinate, restrain the cost of, and improve the quality of essential health services, including preventive and emergency services, through development of integrated health care delivery systems or networks in rural areas and regions. Grants are made to rural public or non-profit private entities that include three or more health care providers or other entities that provide or support the delivery of health care services.	The program is meant to benefit medically underserved populations in rural areas. The administrative headquarters of the grantee must be in a rural county or a rural census tract. Otherwise the organization must exclusively provide services to a MHC under section 330(g) or be a Native American Tribal or quasi-tribal entity for services delivered on reservation or recognized tribal lands.	Health Centers Consolidation Act; PHS Act, Title III, Section 330A(c)	Ms. Eileen Holloran, Grant Programs Coordinator, ORHP, (301) 443-7529 $30,000,000

The Rural Health Clinics program was set up to increase access to health care for rural, medically underserved areas and to expand the use of midlevel practitioners, e.g., PAs, NPs, CNMs, etc., in rural communities. The Health Care Funding Agency (HCFA) is responsible for certification and oversight of RHCs. Certified RHCs receive cost-based reimbursement from Medicare and Medicaid through HCFA. RHCs must employ a PA, NP or CNM to provide services 50% [or is this 60%] of the time the center is open unless they receive a waiver from HCFA.	In order to receive Medicare/Medicaid reimbursement, RHCs must be located in both a rural area and a designated Medically Underserved Area. For RHCs, rural is defined as those areas that are designated as "non- urbanized" by the Census Bureau. A shortage area can be a federally designated HPSA or MUA or an area designated by a state, and approved by DHHS, as underserved.[1]	Rural Health Clinics Act of 1977 (public law 95-210) and Section 1861(aa) of the SSA.	
Federally Qualified Health Center "Look-alikes" FQHC look-alikes are facilities that meet all the requirement of the Community Health Center program and receive Medicare and Medicaid cost-based reimbursement but do not receive Community Health Center Grant support. FQHC Look-alikes must be a public or private nonprofit entity. Application are reviewed by HRSA and forwarded to HCFA who designates applicants.	FQHC Look-alikes must serve a designated MUA or MUP and meet the requirements of section 330. Applicants must also demonstrate the need in the area for primary health care services and that it is serving those most in need within the service area. *[from PIN 2000-02]*		
Grants to States for Operation of Offices of Rural Health (93.913) is a matching grant program to states for the establishment and operation of Offices of Rural Health. The offices are meant to coordinate rural health programs throughout the state, provide information and TA and improve availability of health professional in rural areas.	While there is no direct requirement that grant funds be used in HPSAs or MUA, they are to be used to improve health care in rural areas – areas in which access to and availability of care is difficult. Also, one listed beneficiary of these grants is underserved populations in rural areas.	Public Law 101-597; PHS Act, Section 338J	Mr. Robert Anson, Director, State Office of Rural Health Grant Program, ORHP; 301/443-0835 $ 3,000,000

[1] This includes: areas with a shortage of personal health services (under 330(b)(3) or 1302(7)); health manpower shortage areas described in 332(a)(1)(A); high migrant impact areas described in 329(a)(5); and areas designated by a state governor and certified by DHHS as an area with a shortage of personal health services.

***Development and Coordination of Rural Health Services (93.223**) provides funds to improve health care delivery systems to rural areas. Grants are given to increase the dissemination of information regarding rural health issues, providing technical assistance, and developing networks to improve the R&R of health professionals in rural areas.	Funds are available to non-profit, private organizations that are committed to improvements in rural health care. While there is no direct requirement that a project serve a specific MUPs, the grant must benefit medically underserved populations in rural areas.	PHS Act, Section 301	Mr. Jerry Coopey, Office of Rural Health Policy, HRSA; 301/4430835
***Cooperative Agreements for Substance Abuse Treatment and Recovery Systems for Rural, Remote and Culturally Distinct Populations (RRCD) (93.122)** funds projects which design model systems of substance abuse and/or dependence intervention, treatment and recovery services for rural, remote and culturally distinct populations.	Activities are designed services for individuals with culturally distinct characteristics (e.g., Native Americans, recent immigrants and farm workers) and who reside in areas that are rural[2], remote or geographically isolated. Projects to enlarge existing program will only be considered in cases where the applicant can document significant unmet demand for treatment on the part of the target population.	PHS Act, Section 510(b)	Tom Edwards, Chief, Organization of Services Branch, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, (301) 443-8802 FY 99 $0
Cooperative Agreements to Improve the Health Status of Minority Populations (93.004) provides funds for activities, which potentially improve the health status of racial/ethnic minorities.	One of the priorities given is for the funding of projects that serve underserved communities,	PHS Act, Title XVII, Section 1707(d)(1)	Ms. Cynthia H. Amis, Director, Div of Program Ops, Office of Minority Health 301/594-0769 $ 7,838,650 ($0 in FY00)
Emergency Medical Services for Children (EMS for Children) 93.127 supports demonstration projects for the expansion and improvement of EMSs for children.	Priority will be given to projects targeted toward populations with special needs, including Native Americans, minorities and the disabled.	Public Law 102-410; PHS Act, Section 1910	EMSC program Director, Maternal and Child Health Bureau, HRSA, PHS 301/ 443-6192 $ 15,000,000

[2] A rural area is defined as an area where a significant number of the population lives in the country, in small towns of less than 5,000 or in a county with a major city (greater than 10,000), but where at least 30 to 40 percent of population live in the country.

Project Grants for Renovation or Construction of Non-Acute Health Care Facilities and Other Facilities (93.887) Grants to public or other nonprofit entitles to renovate, expand, repair, equip or modernize non-acute health care facilities. Grants may not exceed 80% of the cost of the project unless that grantee is located in an areas determined by the Secretary to be a poverty area, in which case the grant may cover 100% of the project cost.	Criteria for selection include that the proposed project will provide services to a MUP. The application must show that needs of racial and ethnic minorities have been considered and that efforts will be made to meet these needs.	PHS Action, Section 1610(b).	Mrs. Charlotte Pascoe, Director, Division of Facilities Compliance and Recovery, Office of Special programs, HRSA; 301/443-4303 $65,000,000
Rural Telemedicine Grants (93.211) demonstrate how Telemedicine can be used as a tool in developing integrated systems of health care, improving access to health services for rural citizens and reducing the isolation of rural health care practitioners. The program will also collect information for a systematic evaluation on the feasibility, costs, appropriateness and acceptability of rural Telemedicine.	There is no requirement that a grant be related to a HPSA or MUA. They do have to serve facilities and providers in rural areas. Grantee must develop show ability to collect data on and participate in an evaluation of telemedicine.	Health Centers Consolidation Act; PHS Act, Title III, Section 330A(c)(3);	Ms. Cathy Wasem, Office for the Advancement of Telehealth, HRSA, PHS; (301) 443-0447 $5,057,035
3. PROGRAMS THAT PROVIDE EDUCATION AND TRAINING FOR PROVIDER TO SERVE IN UNDERSERVED AREAS			
Health Professions Education and Training Grants: Titles VII and VIII of the Public Health Services Act authorizes 40 programs that award grants to health professions training programs. Most of these grants were authorized by the Health Professions Education Partnership Act of 1998 (HPEP Act). Grants are provided to entities for primary care medical, dental, nursing and allied health training for graduate and undergraduate students. One of the purposes of the HPEP Act is to provide training of health care providers to serve in underserved areas. As such, a number of grants require or give priority to programs that train and/or place students in underserved areas. The following 27 grants use HPSA or MUA/MUP designations.			

Centers of Excellence in Health Professionals Education for Minorities (93.157) assists eligible schools in supporting programs to train under-represented minority students in health professions. Grants provide stipends to students. They can also be used to establish and strengthen programs for minority students and faculty and to conduct research on health issues affecting minority groups. Centers provide student training at community-based health facilities.	One of the criteria for funding is that Centers of Excellence "increase the supply of minority health professionals available to serve minority populations in underserved areas." Centers must also provide training at "community-based" health facilities. CHCs are not specifically mentioned.	Excellence in Minority Health Education and Care Act; HPEP Act; PHS, Title VII, Section 739	A. Roland Garcia, Chief, Centers of Excellence Section, Division of Disadvantaged Assistance, BHPr, HRSA; 301/443-2100 $24,218,989
Health Education And Training Centers (HETC) (93.189) provides funds to increase the number of personnel providing health services in the state of Florida, along the border between the US and Mexico and in other urban and rural areas including frontier areas. Centers can also provide health service to population groups, including Hispanics, which have serious unmet health care needs. Awards are made to school of medicine to establish and operate health education and training centers that provide health service, and public education.	There is no requirement that service areas be a designated MUA. However, one criteria of selection is that the project address unmet health care needs in States along the border between the United States and Mexico, in Florida, and in other urban and rural areas with populations having serious, unmet health care needs.	Excellence in Minority Health Education and Care Act; HPEP ACT; PHS, Title VII, Section 746(f)	Audrey Koertzelyessy, MPH, Division of Medicine, BHPr, HRSA, PHS; 301/443-6950 $ 3,424,623

Area Health Education Centers (93.107) gives grants to increase the number of personnel providing health services in underserved rural and urban areas. Awards are made to schools to develop regional training through agreements with community-based organizations such as CHCs, MHC, IHC and other clinics located in underserved areas.	The AHEC must specifically designate a MUA or MUP, which will be served by the center and in which clinical training will occur. The grant criteria gives special consideration to centers that serve a higher percentage of underserved minorities.	Excellence in Minority Health Education and Care Act; HPEP Act; PHS, Title VII, Section 751	Louis D. Coccodrilli, Chief, AHEC Branch, Division of Medicine, BHPr, HRSA, PHS; 301/443-6950 $ 8,400,000
Public Health Training Centers (93.188) gives grants to develop the existing public health workforce and improve the infrastructure of the public health system by increasing the public health. Applicants must agree to assess the public health personnel needs of the area, to be served and assist in the planning and development of training programs to meet such needs and to establish or strengthen field placements for students in nonprofit public health agencies.	Public health training centers must specify a geographic area, including medically underserved populations, e.g., elderly, immigrants/refugees, disadvantaged, to be served by the Center that shall be in a location removed from the main location of the teaching facility of the school participating in the program.	HPEP Act; PHS Act, Title VII, Section 766	Angela Gonzalez Willis, Ph.D., Public Health & Dental Ed., BHP, HRSA, Telephone: (301) 443-6896 $ 1,984,340 ($0 estimated for FY00)

Project Grants for Facilities to Improve the Health Status of Minority Populations (93.005) provides funds to construct or renovate facilities that promote the health status of minority underserved communities and populations. Grants are made for facilities used to provide health services or in health education.	Criteria for funding include the need and demand for the project and the extent to which the project will allow for the delivery of the most needed health care services to disadvantaged populations.	HPEP Act, PHS Act Title XVII, Section 1707(e)	Ms. Tuei Doong, Deputy Director, Office of Minority Health, Office of Public Health Service, Office of the Sec., DHHS; 301/443-5084 $1,000,000 ($0 in FY 00)
Health Professions Education and Training Grants Specific to Medically Underserved Communities these include a number of grants to develop training programs and providing financial assistance to graduate and undergraduate students in a variety of health disciplines. The majority of grants are to develop primary health care. [3]	Preference is given to applicants that have the principal focus on serving residents of medically underserved communities and that have a high rate for placing graduates in such settings. In most, the applicant documents their history in serving and placing students and graduate in these areas.	HPEP Act; PHS Act, Title VII and VIII	Varies

[3] The programs that give preference to grants focusing on medically underserved communities include: Allied Health Projects **(**93.191); Grants for Dental Public Health (93.236); Professional Nurse Traineeships (93.358); Nursing--Special Projects (93.359); Graduate Training in Family Medicine (93.379); Predoctoral Training in Family Medicine (93.896); Faculty Development in General Internal Medicine and/or General Practice (93.900); *Grants for Nurse Anesthetist Faculty Fellowships (93.907); Nurse Anesthetist Education Programs (93.916); Health Administration Traineeships and Special Projects Program (93.962); *Academic Administrative Units in Primary Care (93.984)

Nurse Practitioner and Nurse-Midwifery Education Programs (93.298) Financial assistance RNs to train as Nurse Practitioners or Nurse-midwives. The major purpose is to increase the pool of professionals to deliver primary health care.	One of the criteria for funding is the potential of graduates to serve in a primary care shortage area.	HPEP Act; PHS Act, Title VIII, Section 822	Dr. Irene Sanvold, Division of Nursing, BHP, HRSA, PHS; 301/ 443-6333 $17,177,556
Residencies and Advanced Education in the Practice of General Dentistry (93.897) gives grants to increase training opportunities in postdoctoral general dentistry. Funds can be used to support existing accredited programs in General Dentistry and to support the development of new programs.	The program emphases several things including applications which encourage practice in underserved areas and in meeting the needs of special populations.	HPEP Act; PHS Act, Title VII, Section 747	Dr. Kathy Hayes, Public Health & Dental Education Professions, BHP, HRSA, PHS; 301/443-4832. $ 3,747,929
Inter-disciplinary Training for Health Care for Rural Areas (93.192) gives grants that provide or improve access to health care in rural areas by training health care providers, increase the R&R of practitioners in rural areas and undertake other research on delivery of health care in rural areas.	Criteria for selection include the need to show an ability and commitment to provide training to professionals to practice in rural areas. No direct mention of HPSA/ MUAs is made.	HPEP Act; PHS Act, Title VII, Section 754	Ms. Judith E. Arndt, CDR US PHS, Interdisciplinary, Geriatrics and Allied Health Branch, BHP, HRSA 301/443-6867 $ 4,275,900
Health Professions Education and Training Grants Programs – General A number of grant programs that provide for training of health care providers. Grants are given for primary care, specialties and allied fields and for the training of midlevel providers. Many of the specialty field include whose needed by underserved populations, e.g., pediatric, geriatrics.[1]	Criteria for these grants do not specifically talk about HPSAs or MUAs. However, they are covered by the basis provisions for Title VII & VIII project that, "To the extent practicable, grantees under this section shall establish linkages with health care providers who provide care for underserved communities and populations." Many of these grants either provide training for midlevel providers or training in fields often related to MUPs, e.g. geriatrics	HPEP Act; PHS Act, Title VII & VIII;	Varies

DSD - Division of Shortage Designation HHS - Department of Health and Human Services HPSA - Health Professional Shortage Area IMU - Index of Medical Underservice MUA - Medically Underserved Area MUP - medically underserved population NHSC - National Health Service Corps OTA - Office of Technology Assessment USIA - United States Information Agency

[1] These grants include: Grants for Preventive Medicine & Dental Public Health (93.117); Nurse Anesthetist Traineeships (93.124); Pediatric Residency in Primary Care (93.181); Geriatric Training Regarding Physicians and Dentist (93.156); Residence Training in General Internal Medicine and/or General Pediatrics (93.884); Physician Assistant Training in Primary Care (93.886); Grants for Faculty Development in Family Medicine (93.895); *Public Health Traineeships (93.964); and *Grants for Geriatric Ed. Centers (93.

Appendix B:

Two-Year Projected Budget

Two-Year Projected Budget for Primary Care Physician Database

Projected Initial Budget for Database Development and Maintenance--2001

Item	Amount
Personnel - Salary and Fringe (2 f/t FTE's, 2 p/t FTE's, 1 intern)	$195,000
Computers and Equipment	$15,000
Electronic Database Support	$ 20,000
Travel	$ 1,000
Materials and Supplies	$ 3,000
Printing and Copying	$ 1,000
Mail/Postage	$ 5,000
TOTAL	**$240,000**

Projected Budget for Ongoing Database Maintenance--2002

Item	Amount
Personnel - Salary and Fringe (2 f/t FTE's.)	$95,000
Electronic Database Support	$ 20,000
Travel	$ 1,000
Materials and Supplies	$ 3,000
Printing and Copying	$ 1,000
Mail/Postage	$ 5,000
TOTAL	**$125,000**